F. Adjustments For Out-of-State Providers

1. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid patient must be prior authorized by the Department, based upon review and recommendation by the Peer Review Organization (PRO).

2. Payment for out-of-state and non-participating Colorado Hospital inpatient services shall be at a rate equal to 90% of the average Colorado Urban or Rural DRG payment rate. Out-of State urban hospitals are those hospitals located within the Metropolitan Statistical Areas (MSA) as designated by the U.S. Department of Health and Human Services.

3. Effective January 1, 1992: When needed inpatient transplant services are not available at a Colorado Hospital, payment can be made at a higher rate (than 90% of the average Colorado Urban or Rural DRG payment rate) for non-emergent services if the provider chooses this payment method. When not reimbursed at a DRG payment rate the out-of-state hospital will be paid based upon the following criteria:

   a. Payment shall be 100% of audited Medicaid costs.

   b. In no case shall payment exceed $1,000,000 per admission.

4. All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical, and financial data to the Colorado Hospital Association Date Bank Program. If a hospital does not report to the Colorado Hospital Association Data Bank, the State agency will send the required format for reporting this data.

G. Free Standing Psychiatric Hospitals (Excluding State Institutions):

1. Effective October 10, 1998, new payment rates for care provided to Medicaid patients under 21 in Cedar Springs Psychiatric Hospital, Centennial Peaks Hospital, and Cleo Wallace Center have been established. The Department analyzed historical Medicaid payment rate data and evaluated the nature of the relationship between hospital cost data and patient length of stay information. Fiscal Year 1987 Medicaid cost data from the participating facilities was used to determine the break points within the 42 day average length of stay, where costs differ substantially. This 1987 data revealed that costs for the first seven days of care were 38% higher than costs for the remainder of the certified stay. Based upon this cost relationship, the existing per diem payments made to these facilities were recalibrated to reflect a "step down" in payment after day 7. The two per diem rates, when paid for the entire 42 day average length of stay, will pay an average amount equal to previous payments to these facilities. Thus, the revision in payment methodology was designed initially to be revenue neutral while providing further incentives for cost containment.

2. For certified days of care in which the patient is awaiting transfer to a more medically appropriate treatment setting outside of the hospital inpatient facility, the Colorado maximum RCCF (Residential Child Care Facility) rate will initially be paid.

3. Effective December 15, 1989, these free-standing psychiatric hospital rates will be updated annually by the methodology outlined in number 1. in the Adjustments For Exempt Providers section above.

4. Effective July 1, 1989 Cedar Springs Psychiatric Hospital was terminated as a Colorado Medicaid provider. Effective December 8, 1990 La Plata Psychiatric Hospital became eligible for reimbursement as a Colorado Medicaid provider. Effective July 1, 2002 PSI Cedar Springs Hospital, Inc. became eligible for reimbursement as a Colorado Medicaid provider.

H. Public Process for Hospital Rate-Setting

The State has in place a public process which complies the requirements of Section 1902(a)(13)(A) of the Social Security Act.

II. Family Medicine Program

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the Major Teaching Hospital program, it is not eligible for this program. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Program will be $213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Program will be $228,379. The annual payment shall change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

The Family Medicine Residency Program payment is calculated on a State Fiscal Year (July 1 through June 30) basis and is distributed equally to all qualified providers in 12 equal monthly installments. Payments will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

Total funds available for this payment equal:
State Fiscal Year 2003-04 $1,524,626.

III. Disproportionate Share Hospital Adjustment

A. Federal regulations require that hospitals which provide services to a disproportionate share of Medicaid recipients, shall receive an additional payment amount to be based upon the following minimum criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and

2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area, (that is an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3. Number 2 above does not apply to a hospital in which:

   a. The inpatients are predominantly under 18 years of age; or

   b. Does not offer non-emergency obstetric services as of December 21, 1987.

   The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

   The calculation of the Medicaid inpatient utilization rate will include managed care patient days.

4. For purposes of paragraph 8.A.1., the term "low income utilization rate" means, for a hospital, the sum of:

   a. The fraction (expressed as a percentage)

      i. The numerator of which is the sum (for a period) of (I) total revenues paid the hospital for patient services under a Slate Plan under this title and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

ii. The denominator of which is the total amount of revenues of the hospital for patient service (including the amount of such cash subsidies) in the period; and

b. The fraction (expressed as a percentage)

i. The numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (i) (II) of subparagraph (A) (of section 1923 of the Social Security Act) in the period reasonably attributable to inpatient hospital services, and

ii. The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approach under this title).

5. The calculation of the low income utilization rate will include revenues paid the hospital from managed care entities on behalf of Medicaid beneficiaries.

B. Colorado determination of Individual Hospital Disproportionate Payment Adjustment.

Effective January 1, 1991, hospitals deemed eligible for minimum disproportionate share payment will receive the following payment adjustment:

1. Hospitals with a Medicaid inpatient utilization rate in excess of one standard deviation above the State's mean Medicaid patient day utilization rate will receive a minimum of a 2 1/2% increase in the calculated base or per diem rate. To pay hospitals proportionally for their level of Medicaid inpatient utilization the following schedule will be applied to each specific Medicaid utilization rate:

STANDARD DEVIATION LEVEL ABOVE MEAN	INCREASE IN MEDICAID PAYMENT
1.0-1.19	2.5%
1.2-1.39	3.0%
1.4 -1.59	3.5%
1.6 -1.79	4.0%
1.8 -1.99	4.5%
2.0 -2.19	5.0%

2.2 -2.39	5.5%
2.4 -2.59	6.0%
2.6 -2.79	6.5%
2.8 -2.99	7.0%
3.0 -3.19	7.5%
3.2 -3.39	8.0%
3.4 -3.59	8.5%
3.6 -3.79	9.0%
3.8 -3.99	9.5%
4.0 +	10.0%

2. Hospitals qualifying under the low-income utilization rate formula, but not under the Medicaid inpatient utilization rate formula, will receive at a minimum 0.1% increase in payment. To pay hospitals proportionately for their level of low-income utilization, the following schedule will be applied to each specific low-income utilization rate:

LOW-INCOME UTILIZATION PERCENT	INCREASE IN MEDICAID PAYMENT
25% - 49.99%	0.10%
50% - 74.99%	0.15%
75% - 99.99%	0.20%
100% +	0.25%

3. Hospitals qualifying under both formulae will receive only the Medicaid inpatient utilization adjustment.

4. Effective January 1, 1994, no hospital can be considered to be a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of at least one-percent.

5. Disproportionate share amounts shall be based upon the recalculated base rate for affected facilities (prospectively determined annually in conjunction with base rate changes.) The percentage of Medicaid patients in each facility used to calculate the appropriate disproportionate share payments (if any) shall be based upon the most recent Colorado Hospital Association Data Bank information available, and information from hospitals not participating in the Data Bank describing total patient days and Medicaid days. This information received by the department will be used to assure that all Colorado hospitals receiving Medicaid payments will be included in the calculation of disproportionate share amounts. Data Bank information will be subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care.

6. Effective February 22, 2002, the payment adjustment, as described above in this subsection and commonly known as Pre-Component 1, is suspended.

7. Effective July 1, 2002, the Individual Hospital Disproportionate Share Payment Adjustment calculation, as described above in this subsection and commonly known as Pre-Component 1, is superceded by a new payment method. Hospitals with a Medicaid inpatient utilization rate in excess of one standard deviation above the State's Medicaid patient day utilization rate will receive a predetermined reimbursement for the entire fiscal year distributed on a quarterly basis. This predetermined yearly reimbursement will be based on self-pay and others patient day utilization, excluding Colorado Indigent Care Program days, adjusted for each facility's Colorado Medicaid fee-for-service case mix and the appropriated dollars by the General Assembly. Self-pay and others patient day utilization will be as reported by the most recently available Colorado Hospital Association Data Bank information. Others patient day utilization excludes clients reported as Medicare, Medicaid, Champus, Managed Care and Commercial. The Colorado Indigent Care Program days will be as reported in the corresponding Colorado Indigent Care Program annual report. The Colorado Medicaid fee-for-service case mix will be obtained from the Colorado Foundation for Medical Care corresponding submitted report to the Department and will be set equal to one if unavailable. If the eligible hospital does not report to the Colorado Hospital Association Data Bank, the self-pay and others patient day utilization will be directly reported by the hospital to the epartment. An eligible hospital will receive a percentage of the appropriated dollars equal to that hospital's percentage of the self-pay and others patient day utilization, excluding Colorado Indigent Care Program days, adjusted for each facility's Colorado Medicaid fee-for-service case mix relative to all eligible hospitals.

8. Effective July 1, 2003, the payment adjustment, as described above in this subsection and commonly known as Pre-Component 1, is suspended.

9. Effective July 1, 2003, Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a Low-Income payment.

10. Effective July 1, 2003, Hospitals deemed eligible for minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "Low-Income Shortfall payment," which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

    As required by federal regulations this payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider. Self Pay Days, Other Days and Medicaid Days will be reported by the provider for the most recent year for which data are available. As required by Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific uncompensated costs.

    For this section, Self Pay Days, Other Paid Days, Medicaid Days and Total Days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report the requested Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

The funds available for the Low-Income Shortfall payment under the Disproportionate Share Hospital Allotment are limited by the regulations set by and federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for this payment equal:
State Fiscal Year 2003-04 $1,031,000

C. Colorado determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program and Bad Debt.

1. Effective July 1, 1993 Component 1 shall be superceded by a Disproportionate Share Adjustment payment method (herein described as Component 1a) which shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, disproportionate Share Hospital Adjustments, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

   a. Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Programs reimbursements.

b. For each hospital that qualifies under this section D, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year. This cost data will be inflated forward from the year of the most recent available report (using the CPI-W, Medical Care for Denver) through June 30 of the fiscal year payment period. The Colorado Indigent Care Program costs, patient payments, and Program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Program, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit. Aggregate disproportionate share hospital payments will not exceed the published disproportionate share hospital limitations.

2. Effective for the period from June 1, 1994 to June 30, 1994: each facility will receive a payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program Patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered proportionately from all participating hospitals. The State will use historical data from the SFY 91/92 Colorado Indigent Care Program Annual Report to develop the prospective payment rate. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State, (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).